Washington State Department of Health

Office of Emergency Medical Services and Trauma System

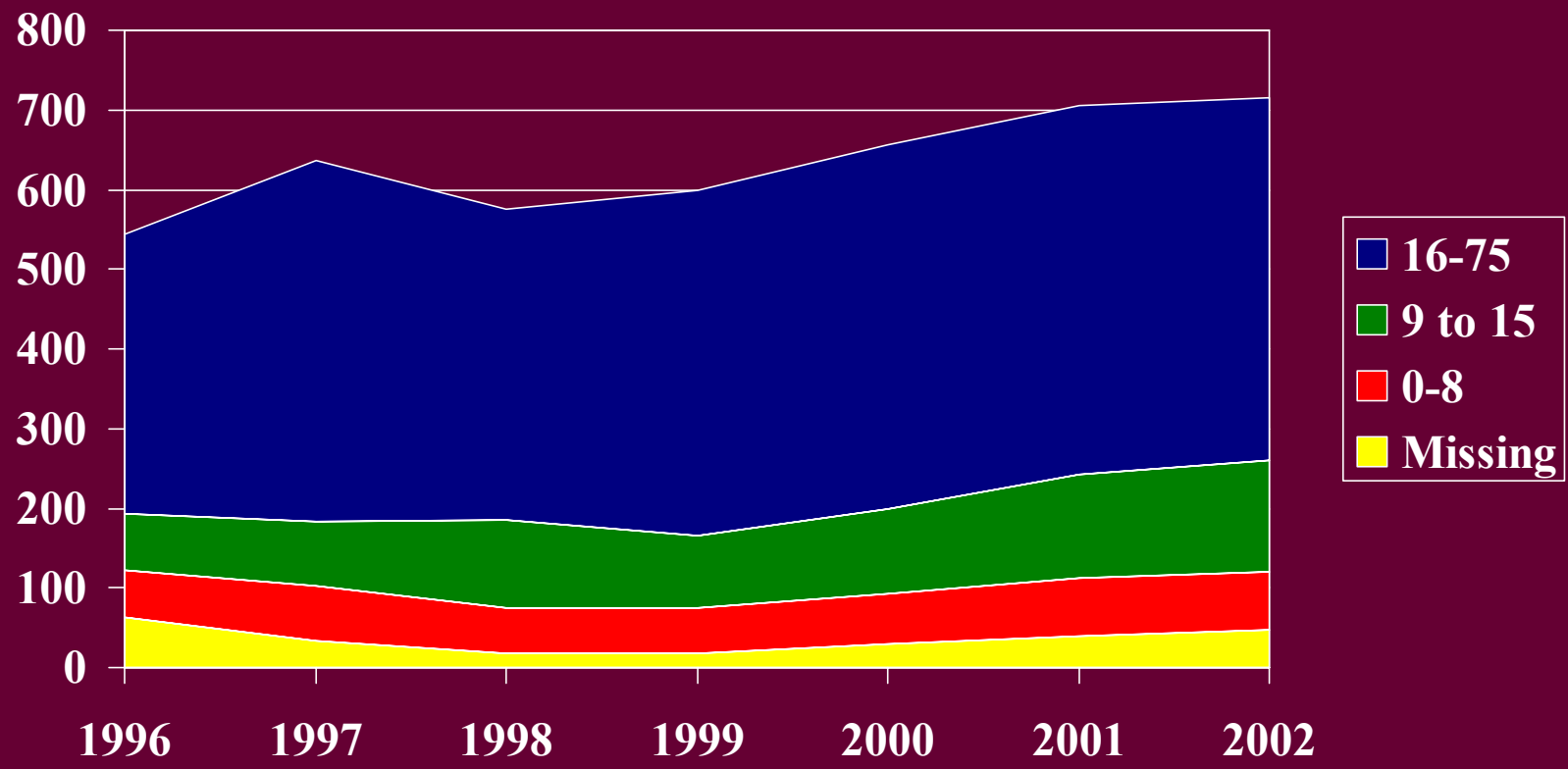
Death Data for QI

EMS & Trauma Steering Committee

November, 2003

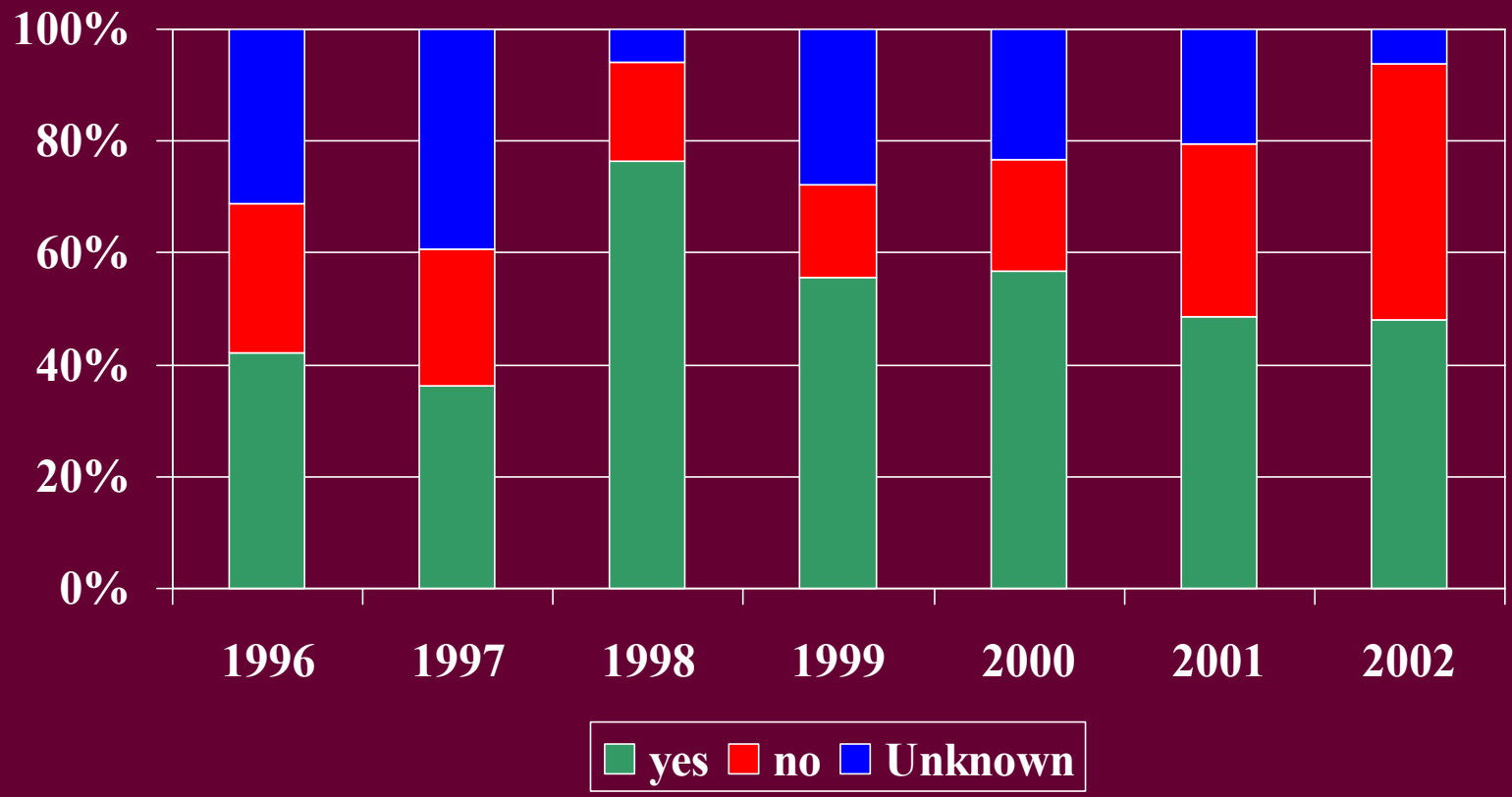
Trauma Registry Deaths by ISS

(State Inclusion Criteria)

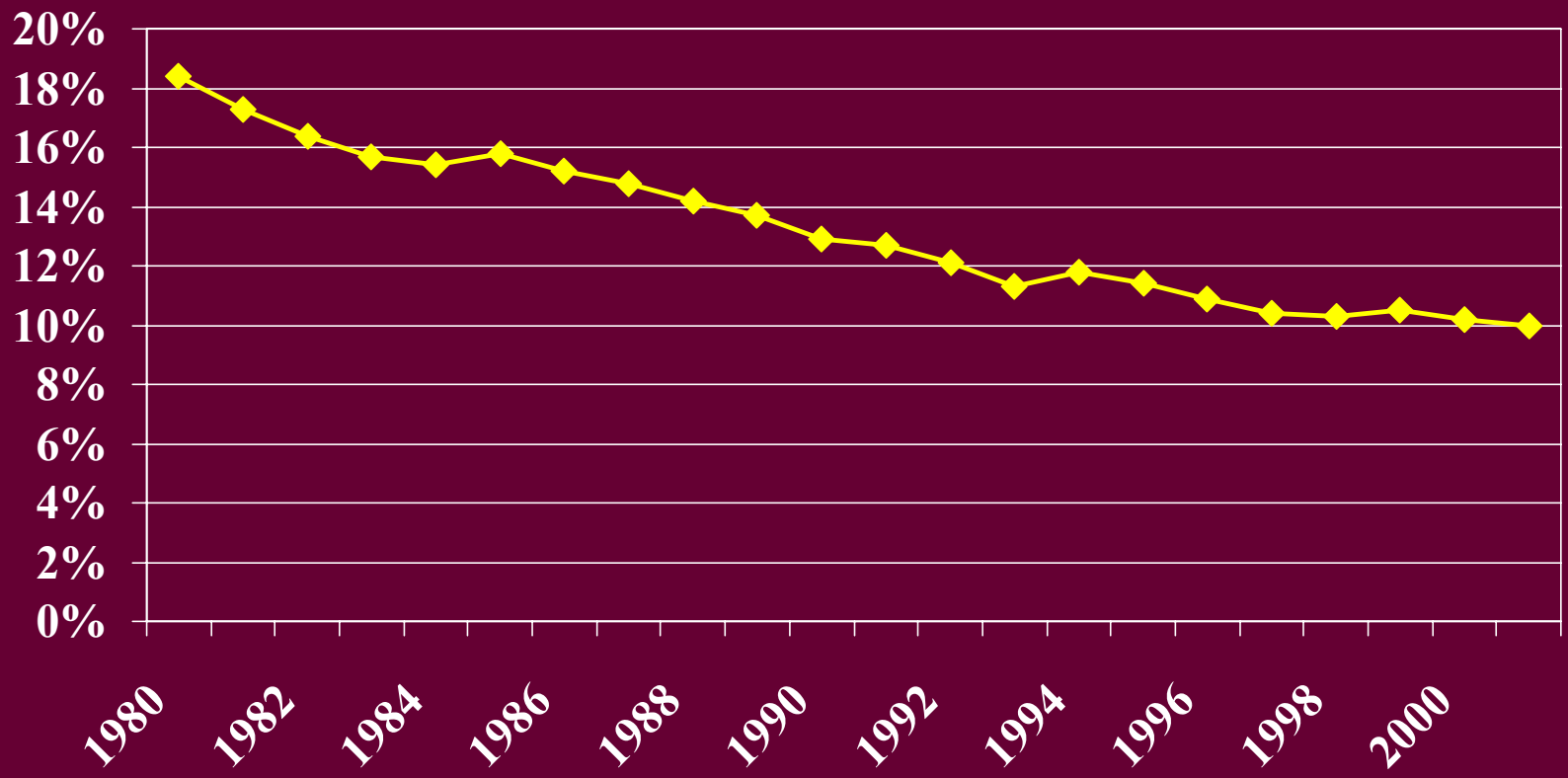


Trauma Registry Deaths with Missing ISS
(State Inclusion Criteria)

Trauma Registry Deaths with Missing ISS by Autopsy Performed
(State Inclusion Criteria)



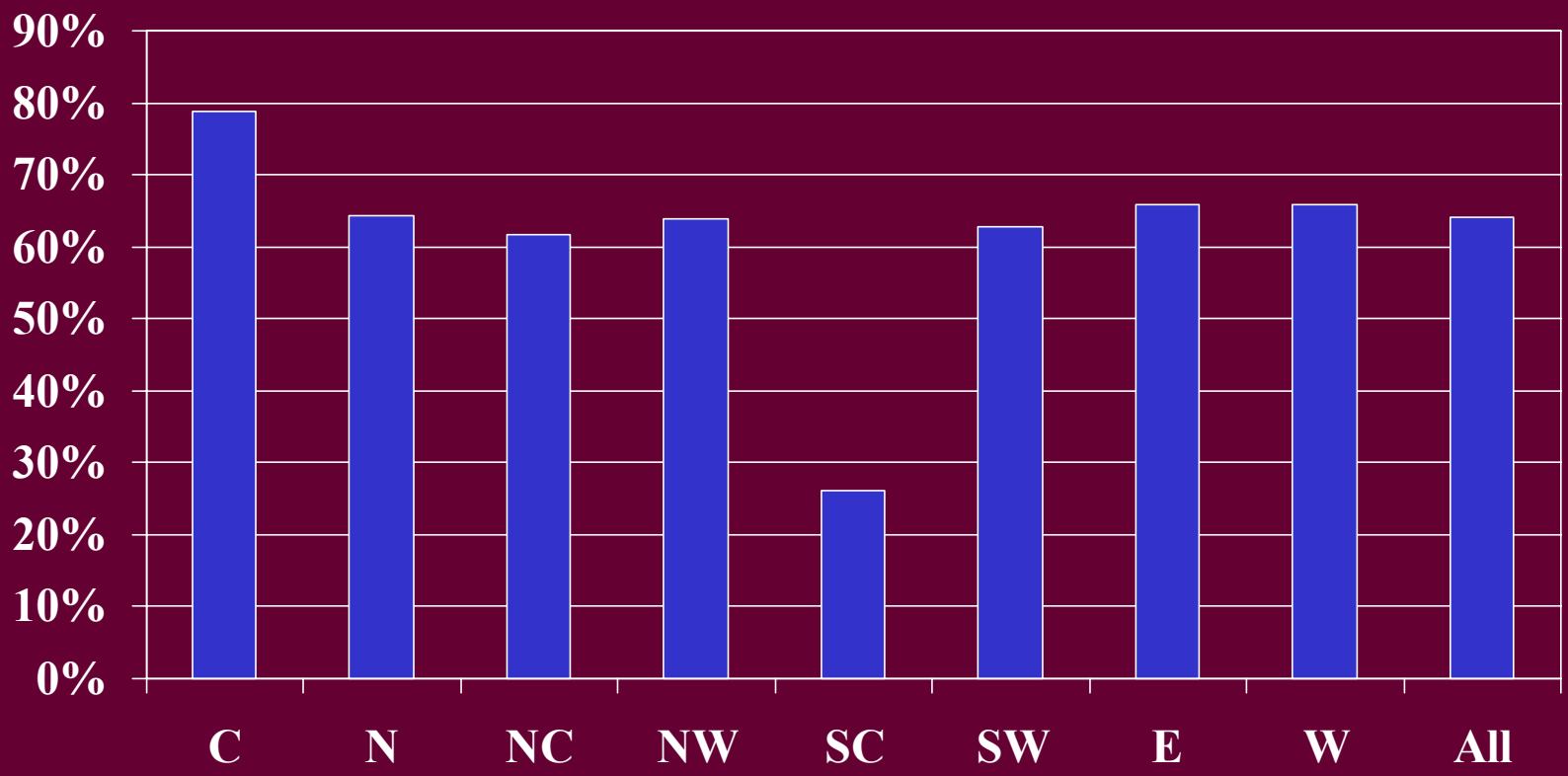
Percent of Deaths with Autopsy
(All Deaths, Washington State)



Source: Center for Health Statistics, DOH

% Autopsied by Region of Death

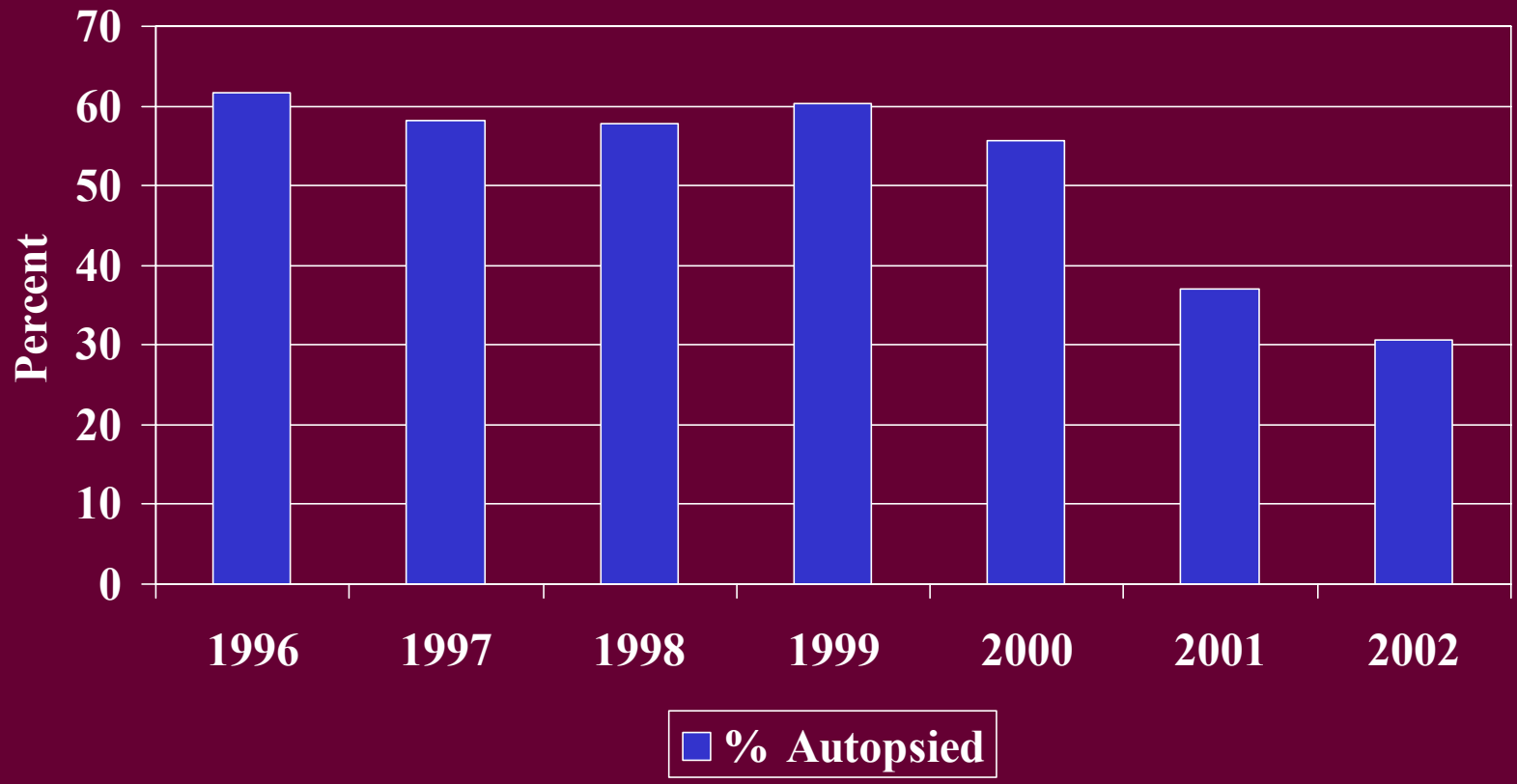
Year 2000, All Injury Deaths



Source: Center for Health Statistics, Death Records

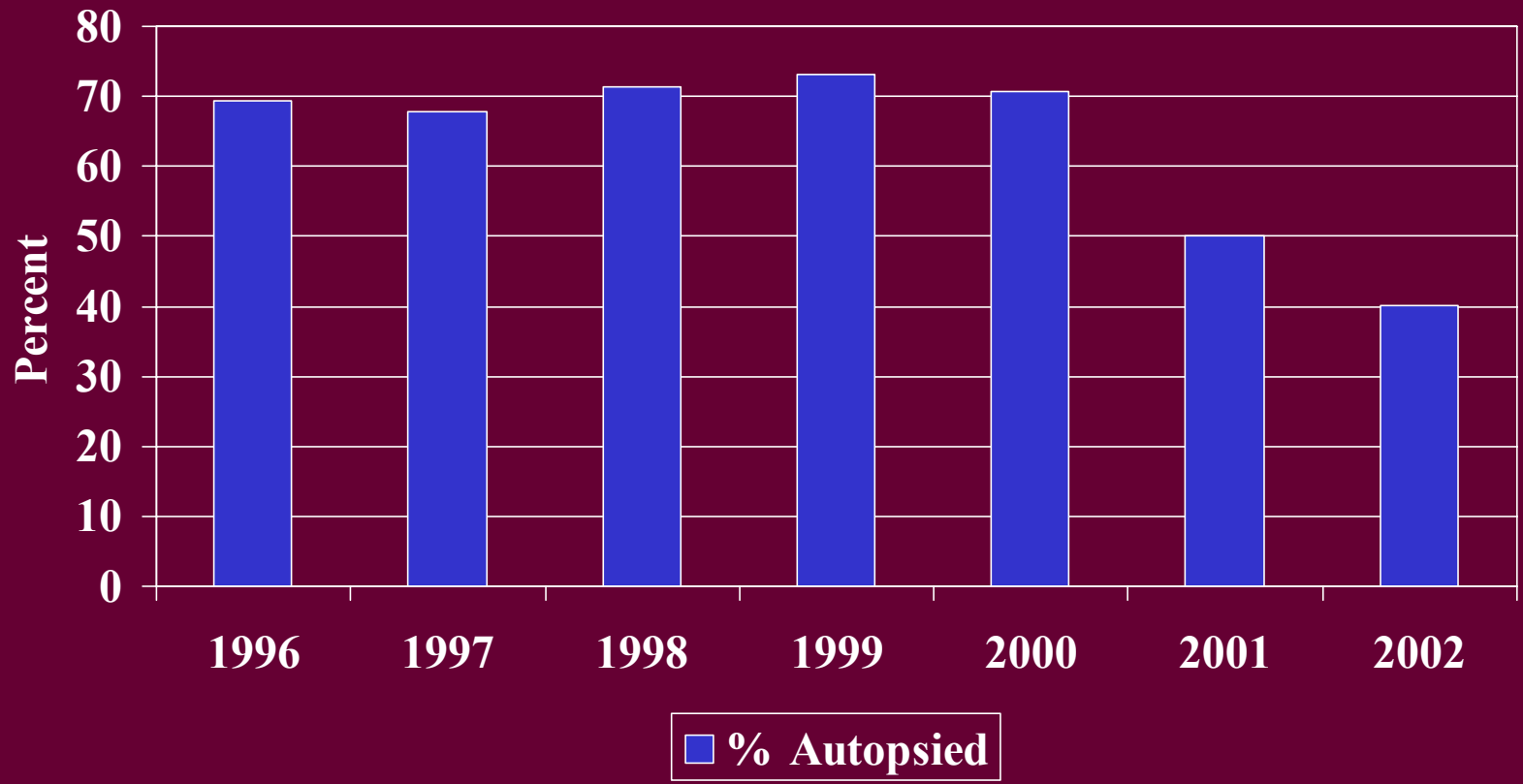
Trauma Autopsies

Registry Reported Deaths, All Ages

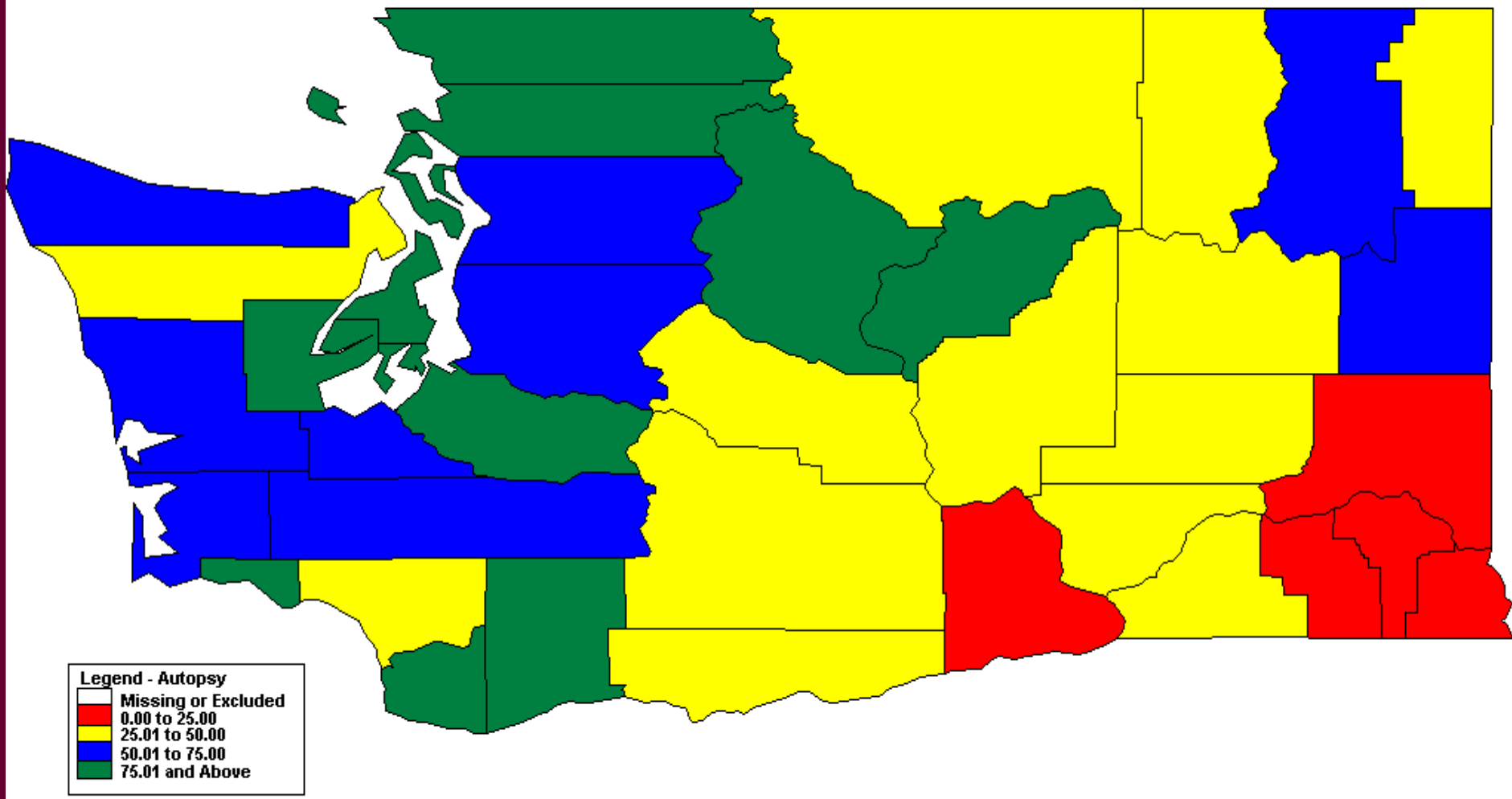


Trauma Autopsies

Registry Reported Deaths, Age<70



Autopsies for Out-of-Hospital Trauma Deaths



Source: Center for Health Statistics. Year 2000

Examples of Deaths with Low Recorded Severity (ISS=1) & No Autopsy

Age	Mechanism	Team Activation	Injury	Time to Death
34	Cut/pierce	Modified	Open wound of neck (other) w/o mention of complication	3 hrs, 11 min.
18	MV Occup	Full	Facial contusion, intracranial injury (other)	17 min
20	Firearm	None	Open wound of hand	2 hrs, 42 minutes
19	Struck by/against	Full	Other open wound of head	3 hrs, 15 min.

Why do we need coroner/ME involvement?

- 2/3 of trauma deaths occur out of hospital and are not reported to the registry. Opportunities for prevention and system enhancement
- Identification of prehospital (EMS) care issues (e.g., improper intubations)
- Identification of hospital care issues (e.g., missed diagnoses, delays to OR)
- Accurate coding of injuries
- Survivability analysis

RCW 68.50.105

Autopsies, post mortems -- Reports and records confidential -- Exceptions.

Reports and records of autopsies or post mortems shall be confidential, except that the following persons may examine and obtain copies of any such report or record: The personal representative of the decedent as defined in RCW 11.02.005, any family member, the attending physician, the prosecuting attorney or law enforcement agencies having jurisdiction, public health officials, or to the department of labor and industries in cases in which it has an interest under RCW 68.50.103.

Challenges

- Trauma System Act (RCW 70.168) does not mention autopsy reports
- Medical examiners and coroners question their authority to release autopsy information for regional trauma QI
- Decreased number of autopsies overall due to reduced funding

Recommendations from Dr. Jurkovich

- Address the patient confidentiality concerns of the coroners/medical examiners
- Enact legislative change to make autopsy reports part of the required state Trauma Registry data (access to reports).
- Consider options to support funding for autopsies of trauma deaths
- Explore ways to increase coroners/ME participation in regional QI committees